2019

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See also Donnelly et al., p. 1482.

From a public health perspective, single-payer health care financing embodies collective action to secure universal, financially sustainable health care access as a public good and social determinant of health. In the United States, however, health care is financed through a fragmentary mix of public coverage, private coverage, publicly financed but privately administered coverage, and substantial out-of-pocket expenditures. Private insurers assert their interest in prevention, but insurers' incentives are not well aligned with farsighted public health goals.[1] Because Americans are segregated into hundreds of plans —with many left out altogether —the population served by any given payer does not reflect the US population as a whole.

If public health care financing is to become more universal in the United States (a big "if"), it will likely be pioneered state-by-state, much like Canada's single-payer system began in the provinces.[2] Several states are seeking to succeed where federal reformers have failed, by using Medicaid as a platform for a public-option or single-payer program. The "Medicaid for All" label, widely used by politicians and commentators, is somewhat misleading. State-level proposals typically rely on the infrastructure that states already have in place for Medicaid but eliminate means testing and special benefits, such as long-term-care insurance, that define Medicaid as fundamentally different from other forms of coverage, private or public. Coverage would be state-financed with help from federal funds obtained via administrative waivers or facilitating federal legislation. Coverage could be administered by a state agency or through contracts with private administrators. A public-option approach would allow at least some residents to buy into the program as an alternative to private insurance, whereas a single-payer approach would aim to cover as many residents as possible and could eliminate employer-based coverage. Some reformers advocate for a public option as a "glide path" to a single-payer program.

This editorial focuses on one choice among the many choices that reformers face: what role will states play in financing and administering more universal public health coverage? As a long-term goal, federal reform modeled on the Canada Health Act could enshrine states as administrators of federally financed coverage. In the short term, Democrats would be wise to gather support for state-by-state experimentation with public-option and single-payer reforms rather than focusing exclusively on reforms built on Medicare, in which states play no role.

STATE-LEVEL REFORM —BENEFITS AND DISADVANTAGES

As I have argued elsewhere,[3] compared with federal single-payer reform, a state-level approach offers enhanced opportunities to integrate public health goals into health care financing and administration. Regulations and programs that influence the social determinants of health operate primarily at the state and local level. In contrast to a state-by-state approach, federal single-payer reform could further federalize policies on healthy eating, active living, tobacco control, overdose prevention, and more, possibly at the expense of more progressive approaches in some states.

Through value-based reimbursement, payers are increasingly holding providers financially responsible for the health of the populations they serve.[4] But the focus is on insured patients over an annual budget, whereas public health must serve the entire community—especially the most vulnerable—throughout the life course. Chances are slim that the insurer who reimburses a pediatrician for talking to a vaccine-hesitant parent will be the same one bearing the costs of treating an infant infected by the unvaccinated child. The company reimbursing treatment for a 14-year-old person's nicotine dependence likely will not be responsible for health care costs if he develops cancer decades later.

Many barriers preclude enhanced integration between health care and public health.[5] Eliminating (or dramatically reducing) fragmented financing could remove one barrier by aligning incentives. There would be near-total overlap between the primary payer for health care goods and services (taxpayers) and those who exercise control over the most crucial social determinants of health (voters). State-level single-payer health care would allow for better harmonization of health care and public health goals, giving state taxpayers and voters greater control over both.

However, implementing single-payer or public-option reforms state-by-state has disadvantages, which I am exploring in works in progress. First, many federally eligible Medicaid enrollees receive benefits tailored to their needs—such as long-term care, developmental screenings, and behavioral

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This editorial was accepted August 15, 2019.

doi: 10.2105/AJPH.2019.305345

interventions—that could be deemed too expensive to cover in a more universal program. Second, Medicaid eligibility and benefits already vary by state, contributing to geographic disparities[6] that could be exacerbated by state-driven reforms. Finally, privatized managed care plans have made deeper inroads into Medicaid than Medicare and might play a larger role in a state-level program than a federal one.

If federal officials choose to facilitate state experimentation, they should ensure that funds are not diverted from federally eligible enrollees to the general population or from less generous states with greater needs to better-off states adopting progressive reforms. State officials must carefully assess whether private contractors can be adequately regulated to secure the goals of reform. If carefully managed, the disadvantages may be outweighed by the benefits in terms of what reformers learn from state experimentation and the potential increase in political viability of a nationwide, but state-administered, program.

EMERGING LEGAL PLAYBOOK

The political environment may be more favorable for single-payer and public-option proposals in individual states where progressive voters have sway, but state lawmakers face legal hurdles not applicable to federal legislators. First, nearly all state legislatures operate under a balanced budget requirement, at least with respect to the general fund. Second, The Patient Protection and Affordable Care Act (ACA; Pub L No. 111-148, 124 Stat. 855 [March 2010]) and Medicaid law impose constraints on the use of federal funds by states, and the flexibility afforded by administrative waivers (granted at the discretion of the Secretary of Health and Human Services) requires careful navigation to ensure that stringent requirements are met. Third, it is unclear whether the federal courts will interpret the federal Employee Retirement Income Security Act of 1974 (ERISA), which preempts state authority to regulate employer health benefits, to bar the state payroll taxes that could be used to redirect employer contributions toward financing a single-payer plan.[7]

Despite these obstacles, a state-level single-payer playbook is beginning to take shape. State lawmakers could maximize federal funds under existing programs by expanding Medicaid eligibility and fostering their state-based health insurance exchanges, repurpose those funds to finance public-option or single-payer coverage by using Medicaid Section 1115 and ACA Section 1332 waivers, and develop new single-payer revenue streams that avoid ERISA preemption. This would require an amenable presidential administration willing to grant waivers, and states would still fall short of covering all residents because waivers would not bring in Medicare beneficiaries. Moreover, states would probably face litigation challenging the diversion of federal funds via waiver and any taxes the state might impose on employers under ERISA. Alternatively, Congress could amend the ACA, Medicaid, and Medicare statutes to permit the use of federal funds to finance state single-payer plans, an outcome that seems more likely in the near term than federal legislation to adopt a national health insurance program. In addition, federal legislation to clarify the boundaries of ERISA preemption could reassure state lawmakers, who generally prefer to avoid protracted court battles even when the law is likely to be on their side.

A PATH FORWARD

Single-payer proponents will have to wait until the presidency or Congress comes under the control of progressive Democrats. In the meantime, interested state lawmakers can take steps to prepare. Maximizing Medicaid eligibility within existing federal law ensures affordable coverage for more residents living in low-income households. It also increases the number whose single-payer coverage could be subsidized by federal funds. Strengthening the ACA exchanges supports subsidized private coverage for residents. It also sustains a platform for offering a public option, making coverage more affordable while bolstering political will required for more radical reforms. AJPH

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CONFLICTS OF INTEREST

The author has no conflicts of interest to disclose.

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